CMS Manual System

Pub. 100-02Medicare Benefit Policy

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 47 **Date: FEBRUARY 15 , 2006**

CHANGE REQUEST 4364

NOTE: Transmittal 46, dated February 13, 2006 is rescinded and replaced by Transmittal 47, dated February 15, 2006. This instruction is being re-communicated to correct the funding statement. The funding statement has been revised. All other information remains the same.

SUBJECT: Therapy Caps Exception Process

I. SUMMARY OF CHANGES: Contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances. There are different categories of exceptions described in the instruction. Documentation requirements relevant to therapy services, which are also applicable to the cap exceptions process, are also included here.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2006
IMPLEMENTATION DATE: No later than March 13, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/Table of Contents
R	15/220/Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
N	15/220.3.5/Documentation Requirements for Therapy Services

III. FUNDING: Funding for implementation activities will be provided to contractors through the regular budget process.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 47	Date: February 15, 2006	Change Request 4364

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SUBJECT: Therapy Caps Exception Process

I. GENERAL INFORMATION

A. Background: Financial limitations on Medicare covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997 and were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005. The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to this dollar limitation may be made when provision of additional therapy services is determined to be medically necessary.

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B. Policy: Section 1833(g)(5) of the Deficit Reduction Act of 2005 provides that, for services provided during calendar year 2006, contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances. Claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Providers do not need to issue an ABN for these benefit category denials

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.1	Contractors shall only apply the exceptions to services provided to Medicare eligible beneficiaries in CY 2006.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.2	The contractor shall presume the beneficiary to be excepted from the therapy cap without submission of request for exception or supporting documentation if the beneficiary meets the conditions described in CMS IOM Pub. 100-04.	X	X	X						
4364.3	The contractor should automatically except beneficiaries with specific conditions or complexities in addition to those described in CMS IOM Pub. 100-04, where the contractor believes, based on the strongest evidence available, that those beneficiaries will require additional therapy treatment days beyond those payable under the therapy cap.	X	X	X						
4364.4	The contractor shall post an article on their Web site related to therapy caps.	X	X	X						
4364.4.1	The article shall detail any circumstances, in addition to those described in CMS IOM Pub. 100-4, under which the contractor will grant beneficiaries an automatic exception to the therapy cap, on the contractor Web site. **NOTE:** We plan to provide some additional information to you via e-mail as a guide in the future.	X	X	X						
4364.5	The contractor shall presume the beneficiary to be excepted from the therapy cap if the beneficiary meets the specific conditions for exception in a contractor's article, posted on the contractor Web site.	X	X	X						
4364.6	The contractor shall require the provider to submit a request for a specific number of additional treatment days after the cap has been reached, not to exceed 15 future treatment days for each discipline (OT, PT, and SLP), when the provider believes the beneficiary will require	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	therapy treatment days in excess of those payable under the therapy cap and the beneficiary does not meet criteria in CMS IOM Pub. 100-04 or the contractor's article for a automatic exception from the therapy cap.									
4364.7	For prospective and retrospective requests, the contractor shall approve any appropriate number of additional treatment days if determined to be medically necessary, for occupational therapy, physical therapy, and speech- language pathology regardless of the number of treatment days requested.	X	X	X						
4364.8	The contractor shall require the provider to document services in accordance with CMS IOM Pub. 100-02, chapter 15, section 220.3 and CMS OIM Pub. 100-04, chapter 5, sections 10.2 and 20.	X	X	X						
4364.9	The contractor shall require the provider to submit the These types of documentation of therapy services are expected to be submitted with any requests for documentation, unless the contractor requests less information: • Evaluation /and certified Plan of Care • Certification • Progress Reports • Treatment Encounter Notes • Justification	X	X	X						
4364.10	The contractor shall utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance where a provider fails to submit all required documentation	X	X	X						
4364.11	The contractor shall consider any additional information the provider chooses to submit with the initial request in addition to the information described above.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.12	The contractor shall require the provider to submit separate requests for exception from the combined physical therapy and speech-language pathology cap and from the occupational therapy cap.	X	X	X						
4364.13	The contractor shall encourage that most requests for exception from the therapy cap be received before the cap is exceeded.	X	X	X						
4364.14	The contractor shall approve any number of additional therapy treatment days retroactively, if they are deemed medically necessary, in the exceptional circumstance where a provider fails to submit a timely request for exception from the therapy cap before it is surpassed.	X	X	X						
4364.15	The contractor shall approve additional therapy treatment days already provided when the request is accompanied by documentation supporting medical necessity of the services.	X	X	X						
4364.16	The contractor shall require the provider/supplier/beneficiary to submit a request for approval of a specific number of additional therapy treatment days, not to exceed 15 per discipline, each time the beneficiary is expected to require more therapy treatment days than previously approved.	X	X	X						
4364.17	The contractor shall grant an exception to the therapy cap, by way of approving additional therapy treatment days, when those additional treatment days are deemed medically necessary based on documentation submitted by the provider.	X	X	X						
4364.18	The contractor shall make the decision within 10 business days of receipt of request and appropriate documentation as to whether an exception to the cap has been made.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364. 19	For all letters, notify the provider what the determination is as practicable.	X	X	X						
4364.20	The contractor shall make the decision within 10 business days of receipt of request and appropriate documentation as to how many retrospective treatment days and how many additional future treatment days, are approved.	X	X	X						
4364.21	The contractor shall make the decision within 10 business days of receipt of request and appropriate documentation that additional therapy treatment days are disapproved if not found to be medically necessary.	X	X	X						
4364.22	The contractor shall inform the provider/supplier/beneficiary, using the standard letter found in CMS IOM Pub. 100-08, section 3.3.1.2, that the decision on the exception request is not an initial determination, and therefore does not carry with it administrative appeal rights.	X	X	X						
4364.23	The contractor shall inform the provider that claims for therapy services where no prior authorization was approved are denied as benefit category denials.	X	X	X						
4364.24	The contractor shall deem additional therapy services requested to be medically necessary when the contractor fails to make a decision within 10 business days of receipt of any request and appropriate documentation.	X	X	X						
4364.25	The contractor shall grant an exception to the therapy cap, approving the number of treatment days requested by the provider/supplier/beneficiary, not to exceed 15 future treatment days, if the contractor does not issue a decision within 10 business days of receipt of any request and appropriate documentation.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.26	The contractor shall allow providers to submit, an additional request for exception from the therapy cap after the first request is denied, only if the patient has undergone a significant change in condition.	X	X	X						
4364.27	The contractor shall not apply the 10-day determination and pre-approval processes to any provider where there is evidence of fraud.	X	X	X						
4364.28	The contractor shall not apply the 10-day determination and exception processes to any provider where there is evidence of misrepresentation of facts presented to the contractor by that provider.	X	X	X						
4364.29	The contractor shall not apply the 10-day determination and exception processes to any provider where a pattern of aberrant billing by that provider is found.	X	X	X						
4364.30	The contractor should develop a process by which requests for exceptions from the therapy caps may be received and logged expeditiously by the medical review department.	X	X	X						
4364.31	The contractor shall submit a Supplemental Budget Request (SBR) that identifies the additional funding that is anticipated to fulfill the above requirements.	X	X	X						
4364.32	The SBR shall only contain the funding and anticipated workload associated with the Therapy Cap Exception process.	X	X	X						
4364.33	The carriers and fiscal intermediaries shall report the therapy cap workload in activity code 21221 under miscellaneous code 01.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.34	Any other funding or workload shifts in the Medical Review line shall be submitted in a separate SBR.	X	X	X						
4364.35	The contractor shall develop a mechanism to track workload and costs associated with the Therapy Cap process and are to provide CMS with that information on a weekly basis.	X	X	X						
4364.36	The weekly report will be due the following Wednesday to CMS_MRStrategies@cms.hhs.gov.	X	X	X						
4364.37	The contractor shall also include the frequency of specific diagnoses that are being submitted to a manual exception.	X	X	X						
4364.38	The contractor shall track the number of requests disapproved by ICD-9 code and report the results to CMS weekly	X	X	X						
4364.39	The contractor shall adjust claims received between January 1, 2006 and such time as this DRA is implemented to apply the therapy cap exception provisions when such services are brought to the attention of the contractor by the provider/supplier/beneficiary.	X	X	X						
4364.40	Contractors shall pay otherwise covered and payable claims, if they are medically necessary, for therapy services when they exceed the therapy limitation and an exception has been granted.	X	X	X						
4364.41	Contractors shall override CWF rejects indicating that a therapy service has exceeded the financial limitation and pay for the service if otherwise covered and payable when the claim contains a KX modifier.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.42	Contractors shall inform providers to include a KX modifier on the claim identified as a therapy service with a GN, GO, GP modifier when an exception has been approved.	X	X	X						
4364.43	Contractors shall consider an episode of outpatient therapy as the time in treatment days from the initial patient encounter for the current condition(s) being treated till the last date of service for that plan of care.	X	X	X						
4364.44	Contractors shall not require more specific documentation than that required in manuals unless other Medicare policies (regulation or statute) require it. However, contractors may request information concerning cases under review when that information is required by policy but unclear or absent in the record.	X	X	X						
4364.45	Contractors shall publish CMS OIM examples of acceptable and unacceptable documentation in educational articles.	X	X	X						
4364.46	Contractors shall not count each minute for each therapy service relative to each billed treatment code, but shall ascertain that the total number of minutes of treatment for services represented by time codes Is consistent with the number of units billed for those services and that the total number of minutes of treatment including untimed codes is consistent with the documentation that the services were provided for a reasonable amount of time.	X	X	X						
4364.47	If a claim is submitted and the cap is exceeded, those services will be denied. The provider/supplier/beneficiary may request and the contractor may retroactively approve an exception to the cap for any number of medically necessary services. Contractors may reopen and adjust the claim if brought to their attention.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.48	Contractors shall recoup funds in accordance with their routine procedures for doing so when they have paid claims in excess of the financial limitation where an exception to the limitation is inapplicable or has been disapproved or was approved based on fraud, misrepresentation or abuse.	X	X	X						
4364.49	Contractors shall revise MSN message 17.13, which appears on all claims containing outpatient rehabilitation services, to now read: 17.13 - Medicare approves a limited dollar amount each year for physical therapy and speech-language pathology services and a separate limit each year for occupational therapy services when billed by providers, physical and occupational therapists, physicians, and other non-physician practitioners. Medically necessary therapy over these limits is covered when received at a hospital outpatient department or when approved by Medicare. <u>Spanish Translation</u> Cada año, Medicare aprueba una cantidad límite por servicios de terapia física y patología del lenguaje. Anualmente también aprueba otra cantidad límite por servicios de terapia ocupacional cuando son facturados por proveedores, terapistas físicos y ocupacionales, médicos y otros practicantes no médicos. La terapia que es medicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio o cuando está aproba por Medicare.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.50	Contractors shall revise MSN message 38.18, which appears on all MSNs, to now read: ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE. <u>Spanish Translation:</u> ALERTA: La cobertura de Medicare estará limitada para los servicios de terapia física ambulatoria (PT, por sus siglas en inglés), terapia de patología del habla (SLP, por sus siglas en inglés), y terapia ocupacional (OT) si son recibidos entre el 1 de enero de 2006 y el 31 de diciembre de 2006. Estos límites son $1,740 para PT y SLP combinados y $1,740 para OT. Medicare paga hasta 80 por ciento de los límites después que se haya pagado el deducible. Estos límites no se aplican a cierta terapia aprobada por Medicare ni a la terapia que usted obtenga en los departamentos de hospital para paciente ambulatorio, a menos que usted sea un residente y ocupe una cama certificada por Medicare en un centro de enfermería especializada. Si tiene preguntas, por favor llame GRATIS al 1-800-MEDICARE.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.51	The contractor shall require the provider to submit documentation, sufficient to support medical necessity, with the request for more therapy treatment days than previously approved.	X	X	X						
4364.52	Contractors shall consider a dictated document completed on the day it is dictated if the identity of the qualified professional is included in the dictation.	X	X	X						
4364.53	Contractors shall consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing if it meets the new standards CMS IOM 100-02, chapter 15, section 220.3.	X	X	X						
4364.54	Contractors shall accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.	X	X	X						
4364.55	Contractors shall pay for otherwise covered outpatient therapy services appropriately provided by assistants or qualified personnel only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment.	X	X	X						
4364.56	Contractors shall not require a qualified professional's interval report for the incomplete interval when unexpected discontinuation of treatment occurs. Determine the necessity of services based on the delivery of services as anticipated in the plan and encounter notes.	X	X	X						
4364.57	Contractors shall not require the contents of interval progress notes to be provided daily in treatment encounter notes. The Treatment Encounter Note is acceptable if it records the date, name of the treatment, intervention, or activity provided, the time spent in services	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	represented by timed codes and the name and professional identity of the individual providing the intervention.									

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.58	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: Listed in business requirements

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** No later than March 13, 2006 **Pre-Implementation Contact(s):** Exceptions Process and Medical Review: Dan Schwartz (daniel.schwartz@cms.hhs.gov) or Kim Spalding (kimberly.spalding@cms.hhs.gov); Clinical and Documentation Issues: Dr. Dorothy Shannon (dorothy.shannon@cms.hhs.gov); Claims Processing: Claudette Sikora (claudette.sikora@cms.hhs.gov) or Yvonne Young (yvonne.young@cms.hhs.gov) Appeals: David Danek (david.danek@cms.hhs.gov) **Post-Implementation Contact(s):** Regional offices	**Funding for implementation activities will be provided to contractors through the regular budget process.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Benefit Policy Manual
Chapter 15 – Covered Medical and Other Health Services

Table of Contents
(Rev.47, 02-15-06)

220 - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance

(Rev.47, Issued: 02-15-06, Effective: 01-01-06, Implementation: 03-13-06)

A comprehensive knowledge of the policies that apply to therapy services cannot be obtained through manuals alone. The most definitive policies are Local Coverage Determinations found at the Medicare Coverage Database www.cms.hhs.gov/med.

A list of Medicare contractors is found at the CMS Web site. Specific questions about all Medicare policies should be addressed to the contractors through the contact information supplied on their Web sites. General Medicare questions may be addressed to the Medicare regional offices.

A. Definitions

The following defines terms used in this section and §230:

ASSESSMENT is included in services or procedures and is not separately payable (as distinguished from Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment which may be payable). Assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment determines, e.g., changes in the patient's status since the last visit/*treatment treatment day* and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgment about progress toward goals and/or determine that a more complete evaluation or re-evaluation (see definitions below) is indicated. *Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.*

CERTIFICATION is the physician's/nonphysician practitioner's (NPP) approval of the plan of care.

The CLINICIAN is a term used in this manual and in Pub 100-04, chapter 5, section 10 or section 20, to refer to only a physician, nonphysician practitioner or a therapist (but not to an assistant, aide or any other personnel) providing a service within their scope of practice and consistent with state and local law. Clinicians make clinical judgments and are responsible for all services they are permitted to supervise.

The EPISODE of Outpatient Therapy – For the purposes of therapy policy, an outpatient therapy episode is defined as the period of time, in treatment days, from the initial patient encounter for the current condition(s) being treated until the last date of service for that plan of care. During the episode, the beneficiary may be treated for more than one condition; including conditions with an onset after the episode has begun (e.g. beneficiary receiving PT for low back pain then sustains a hip fracture from a fall).

EVALUATION is a separately payable comprehensive service *provided by clinician, as defined above,* that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions. The time spent in evaluation does not also count as treatment time.

RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment indicates a significant improvement or decline *or change* in the patient's condition or functional status *that was not anticipated in the plan of care for that interval*. *Although s*ome regulations and state practice acts require re-evaluation at specific intervals*, for Medicare payment, re-evaluations must meet Medicare coverage guidelines. The decision to provide an evaluation shall be made by a clinician.*

INTERVAL of treatment consists of 1 month or 30 calendar treatment days.

NONPHYSICIAN PRACTITIONERS (NPP) means physician assistants, clinical nurse specialists, and nurse practitioners, who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services.

PHYSICIAN with respect to outpatient rehabilitation therapy services means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine, or optometry (for low vision rehabilitation only). Chiropractors and doctors of dental surgery or dental medicine are not considered physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.

PATIENT, client, resident, and beneficiary are terms used interchangeably to indicate enrolled recipients of Medicare covered services.

PROVIDERS of services are defined in §1861(u) of the Act, 42CFR400.202 and 42CFR485 Subpart H as participating hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), hospices, participating clinics, rehabilitation agencies or outpatient rehabilitation facilities (ORF). Providers are also defined as public health agencies with agreements only to furnish outpatient therapy services, or community mental health centers with agreements only to furnish partial hospitalization services. To qualify as providers of services, these providers must meet certain conditions enumerated in the law and enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made. Note that the word PROVIDER in sections 220 and 230

is not used to mean a person who provides a service, but is used as in the statute to mean a facility.

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants *are limited in the services they may provide (see section 230.1 and 230.2) and* may not supervise others.

QUALIFIED PERSONNEL means staff (auxiliary personnel) who may or may not be licensed as therapists or therapist assistants but who meet all of the requirements for therapists with the exception of licensure. Qualified personnel have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP. See §230.5 of this manual.

SIGNATURE means a legible identifier of any type (e.g., hand written, electronic, or signature stamp). Policies in *CMS IOM* Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.4.1.1 (B) concerning signatures apply.

SUPERVISION LEVELS for outpatient rehabilitation therapy services are the same as those for diagnostic tests defined in 42CFR410.32. Depending on the setting, the levels include personal supervision (in the room), direct supervision (in the office suite), and general supervision (physician/NPP is available but not necessarily on the premises).

SUPPLIERS of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701-729, and 486.150-163. Speech-language pathologists are not suppliers because the Act does not provide coverage of any speech-language pathology services furnished by a speech-language pathologist as an independent practitioner. (See §230.3.)

THERAPIST refers only to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §230. Qualifications that define therapists are in §§230.1, 230.2, and 230.3.

THERAPY, or outpatient rehabilitation services, includes only outpatient physical therapy, occupational therapy and speech-language pathology services paid using the Medicare Physician Fee Schedule.

Therapy services referred to in this manual are those skilled rehabilitative services provided according to the standards and conditions in CMS manuals, (e.g., in this chapter and in the Medicare Claims Processing Manual, *CMS IOM* Pub. 100-04, chapter 5),

within their scope of practice by qualified professionals or qualified personnel, as defined in this section, represented by procedures found in the American Medical Association's "Current Procedural Terminology (CPT)." A list of CPT and HCPCS codes is provided in *CMS IOM* Pub. 100-04, Chapter 5, §20, and in Local Coverage Determinations developed by contractors.

Unless modified by the words "maintenance" or "not", the term therapy refers to rehabilitative therapy services as described in §220.2(C).

220.3.5 - Documentation Requirements for Therapy Services
(Rev.47, Issued: 02-15-06, Effective: 01-01-06, Implementation: 03-13-06)

A. General

Therapy services shall be payable when the medical record and the information on the claim form consistently and accurately report covered therapy services. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to the requirements in Medicare Manuals.

These guidelines identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. Additional documentation not required by Medicare is allowed at the provider's discretion. For example, the therapist may chose to document requirements of state or local laws, professional guidelines or the individual practice or facility. The therapist may choose to include narratives that specifically justify the medical necessity of services when those services are reviewed.

Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all legal/regulatory requirements applicable to Medicare claims.

Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function).

B. Documentation Required

These types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

- *Evaluation /and certified Plan of Care. (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;*
- *Certification (physician/NPP approval of the plan required 30 treatment days after initial treatment-or delayed certification);*
- *Progress Reports (when treatment exceeds 10 treatment days or 30 calendar treatment day/one month, whichever is less);*
- *Treatment Encounter Notes (may also serve as Progress Reports when required information is included in the notes); and*

- *For therapy cap exceptions, records justifying services over the cap. A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for use of the KX modifier.*

Contractors shall not require more specific documentation unless other Medicare policies require it. Contractors may request further information to be included in these documents concerning specific cases under review when that information is relevant, but not submitted with records.

For Medicare purposes, dictated documentation is considered completed on the treatment day it was dictated. The qualified professional may edit and electronically sign the documentation at a later date. The date of the documentation is relevant only for the plan of care. However, contractors may require that treatment encounter notes and progress reports be dated within one week of the last date of treatment reported in the evaluation, Progress Report or Treatment Encounter Note.

Justification for treatment must include objective evidence or a clinically supportable statement of expectation that:

- *The patient's condition has the potential to improve or is improving in response to therapy;*
- *Maximum improvement is yet to be attained; and*
- *There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.*

Objective evidence consists of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy.

In documenting records, clinicians must be familiar with the requirements for covered and payable outpatient therapy services as described in the manuals. For example, the records should justify:

- *The patient is under the care of a physician/NPP;*
    - *Physician/NPP care shall be documented by physician certification (approval) of the plan of care; and*
    - *Other evidence of physician involvement in the patient's care may include, for example: order/referral, conference, team meeting notes,*

- *Services require the skills of a therapist.*

    - *Services must not only be provided by the clinician or qualified personnel, but they must require, for example, the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that other staff, caretakers or the patient cannot provide independently. This may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.*

    - *A therapist's skill may also be required for safety reasons, if an unstable fracture requires the skill of a therapist to do an activity that might otherwise be done independently by the patient at home. Or the skill of a therapist might be required for a patient learning compensatory swallowing techniques to perform cervical auscultation and identify changes in voice and breathing that might signal aspiration. After the patient is judged safe for independent use of these compensatory techniques, the skill of a therapist is not required to feed the patient, or check what was consumed.*

EVALUATION/RE-EVALUATION** and **PLAN OF CARE

The initial evaluation, or the plan of care including an evaluation, should document the necessity for a course of therapy through objective findings and subjective patient self-reporting based on the guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language and Hearing Association. Only a clinician may perform an initial examination, evaluation, re-evaluation and assessment or establish a diagnosis or a plan of care.

Evaluation shall include:

- *A diagnosis (where allowed) and description of the specific problem to be evaluated and/or treated. For PT and OT, be sure to include the body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function;*

- *Objective measurements, preferably standardized patient assessment instruments and/or outcomes measurement tools related to current functional status, when these are available and appropriate to the condition being evaluated;*

- *Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and*

- *A determination that treatment is not needed, or, if treatment is needed a prognosis for return to premorbid condition or maximum expected condition with expected time frame and a plan of care.*

When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency, intensity and duration of treatment are implied in the diagnosis and one-time service. The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician. Therefore, when evaluation is the only service, a referral and evaluation are the only required documentation.

Re-evaluations shall be included in the documentation sent to contractors when a re-evaluation has been performed. See the definition in section 220. Re-evaluations are usually focused on the current treatment and may not be as extensive as initial evaluations. Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

Re-evaluation may also be appropriate at a planned discharge. A re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation. Current Procedural Terminology does not define a re-evaluation code for speech-language pathology; use the evaluation code.

See section 220.1.2 for requirements of the plan. The evaluation and plan may be reported in two separate documents or a single combined document.

PROGRESS REPORT

The Progress report provides justification for the medical necessity of treatment. For Medicare payment purposes, information required in Progress Reports should be provided at least once every 10 treatment days or once during the interval, whichever is less. Objective measures of progress should be included when available.

Progress Reports may be provided more often than required when the clinician or qualified professional judges them appropriates. If reports are written more frequently, a qualified professional may write some, but not all, reports in the interval. Elements of interval reports may be written in the encounter notes daily if the provider/supplier or clinician prefers. If each element required in a Progress Report is included at least once during the interval in the encounter notes, then a separate Progress Report is not required.

A clinician must personally perform or actively participate in at least one treatment session during the interval of treatment. Verification of the clinician's supervision or treatment shall be documented by the clinician's signature on the treatment encounter note and/or the Progress Report. A clinician must complete a Progress Report at least once during each interval of treatment. Alternately, the information required from the qualified professional must be included at least once during the interval in treatment encounter notes.

When unexpected discontinuation of treatment occurs, contractors shall not require a qualified professional's interval report for the incomplete interval. Determine the necessity of services based on the delivery of services as anticipated in the plan and encounter notes. When discontinuation of treatment is expected during an interval (i.e., it is anticipated in the plan of care or in either interval or daily encounter notes) a discharge note is required.

The discharge note shall be an interval note covering the period from the last interval note to the date of discharge. At the discretion of the clinician, the discharge note may include additional information, for example, it may summarize the entire episode of treatment, or justify services that may have extended beyond those usually expected for the patient's condition. Clinicians should consider the discharge note the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed. The record should be reviewed and organized so that the required documentation is ready for presentation to the contractor if requested.

<u>Content of Assistant Progress Report</u>

The evaluation and plan of care are considered incorporated into the Progress Report, and information in them is not required to be repeated in the report.

Progress Reports written by assistants supplement the reports of clinicians and shall include:

- *Date of the beginning of the interval that this report refers to;*
- *Date that the report was written (must be during the interval;*

- *Signature, or for dictated documentation, the identification of the qualified professional who wrote the report and the date on which it was written or dictated;*

- *Objective reports of the patient's subjective statements, if they are relevant. For example, "Patient reports pain after 20 repetitions". Or, "The patient was not feeling well on 11/05/06 and refused to complete the treatment session." ; and*

- *Objective measurements (preferred) or description of changes in status relative to each goal currently being addressed in treatment, if they occur. Note that assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively. For example: "increasing strength" is not an objective measurement, but "patient ambulates 15 feet with maximum assistance" is objective.*

Descriptions shall make identifiable reference to the goals in the current plan of care. Since only long term goals are required in the plan of care, the interval report may be used to add, change or delete short term goals or to delete completed long term goals. Assistants may add or change short term goals only under the direction of a clinician. When short them goal changes are dictated, report the order, clinician's name and date. Clinicians verify these changes by cosignatures on the report or in the clinician's interval report. (See section 220.1.2(C) to modify the plan for changes in long term goals).

If a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current interval of treatment. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.

Any consistent method of identifying the goals may be used. Preferably, the long term goals may be numbered (1, 2, 3.,) and the short term goals that relate to the long term goals may be numbered and lettered 1.A, 1.B, etc. The identifier of a goal on the plan of care may not be changed during the episode of care to which the plan refers. Add new goals with new identifiers or letters. Omit reference to a goal after a clinician has been reported it to be met, and that clinician's signature verifies the change.

<u>Content of Clinician (Therapist, Physician/NPP) Progress Reports</u>

In addition to the requirements above for notes written by assistants, the interval report of a clinician shall also include:

- *Assessment of improvement, extent of progress (or lack thereof) toward each goal;*
- *Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report; and*
- *Changes to long or short term goals, discharge or an updated plan of care that is sent to the clinician for certification of the next interval of treatment.*

A re-evaluation should not be required before every Progress Report routinely, but may be appropriate when assessment suggests changes not anticipated in the original plan of care.

Example: The Plan states diagnosis is 787.2- Dysphagia secondary to other late effects of CVA. Patient is on a restricted diet and wants to drink think liquids. Therapy is planned 3X week, 45 minute sessions for 6 weeks. Long term goal is to consume a mechanical soft diet with thin liquids without complications such as aspiration pneumonia. Short Term Goal 1: Patient will improve rate of laryngeal elevation/timing of closure by using the super-supraglottic swallow on saliva swallows without cues on 90% of trials. Goal 2: Patient will compensate for reduced laryngeal elevation by controlling bolus size to ½ teaspoon without cues 100%. The Progress Report for 1/3/06 to 1/29/06 states: 1. Improved to 80% of trials; 2. Achieved. Comments: Highly motivated; spouse assists with practicing, compliant with current restrictions. New Goal: "5. Patient will implement above strategies to swallow a sip of water without coughing for 5 consecutive trials. Mary Johns, CCC-SLP, 1/29/06." Note the provider is billing 92526 three times a week, consistent with the plan; progress is noted; skilled treatment is noted.

TREATMENT ENCOUNTER NOTE

Documentation is required for every treatment day, and every therapy service. The Treatment Encounter Note must record the name of the treatment, intervention, or activity provided, the time spent in services represented by timed codes, the total treatment time (including the untimed code services) and the identity of the individual providing the intervention. The format may vary depending on the therapist and the clinical setting.

The purpose of the Treatment Encounter Note is not to document the medical necessity or appropriateness of the ongoing therapy services (although the encounter note may be used to establish medical necessity if it fulfills the requirements of the Progress Report). The purpose of these notes is simply to create a record of all encounters and skilled interventions that are supervised or provided by qualified professionals to justify the use of billing codes on the claim. Descriptions of skilled interventions should be included in the plan or the interval notes and are allowed, but not required daily. Non-skilled interventions need not be recorded in the encounter notes as they are not billable. However, notation of non-skilled treatment or report of activities performed by the patient or non-skilled staff may be reported voluntarily as additional information if they are relevant and not billed.

Documentation of each treatment encounter will include the following required elements:

- *Date of treatment;*

- *Total timed code treatment minutes and total treatment time. The amount of time for each specific intervention/modality provided to the patient is not required, as it is indicated in the billing, but the billing and the total timed code treatment minutes must be consistent. See CMS IOM, Pub. 100-04, chapter 5, section 20.3 for description of billing timed codes. Identification of each specific intervention/modality provided and billed, for both timed and untimed codes. Frequency and intensity of treatment and other details may be included in the plan of care and need not be repeated in the treatment encounter notes unless they are changed from the plan; and*

- *Signature and professional identification of the qualified professional who furnished or supervised and list of each person who contributed to treatment during that encounter (i.e., the signature of Kathleen Smith, LPT, supervisor, with notation of the assistance of Judy Jones, PTA, when permitted by state and local law).*

If a treatment is added or changed under the direction of a clinician during the treatment days between the interval progress reports, the change must be recorded and justified on the medical record, either in the treatment encounter note or the progress note, as determined by the policies of the provider/supplier. New exercises added or changes made to exercise program help justify that the services are skilled. For example: The original plan was for therapeutic activities, gait training and neuromuscular re-education. "On Feb. 1 clinician added electrical stim. to address shoulder pain."

Documentation of each treatment encounter may also include the following optional elements to be mentioned only if the qualified professional recording the note determines they are appropriate and relevant If these are not recorded daily, any relevant information should be included in the progress report

- *Patient self-report;*
- *Adverse reaction to intervention;*
- *Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.);*
- *Significant, unusual or unexpected changes in clinical status;*
- *Equipment provided; and/or*
- *Any additional relevant information the qualified professional finds appropriate.*

The billing was for 1 unit of ultrasound, one of therapeutic exercise and one gait training. It is assumed the ROM was less than 8 minutes and did not qualify for billing. It is assumed the patient tolerated the treatment unless there is a note to the contrary. See CMS IOM Pub. 100-04, chapter 5, section 20.2 for instructions on how to count minutes. It is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as untimed codes.

Contractors shall not count each minute for each therapy service relative to each billed treatment code, but shall ascertain that the total number of minutes of treatment for services represented by timed codes is consistent with the number of units billed for those services and that the total minutes of treatment, including untimed codes, is consistent with the documentation that the services were provided for a reasonable amount of time. For example, if the timed code minutes equal 40 and the total treatment time is 45 minutes, it is appropriate that three timed codes are billed but unlikely that two untimed services were appropriately provided.